

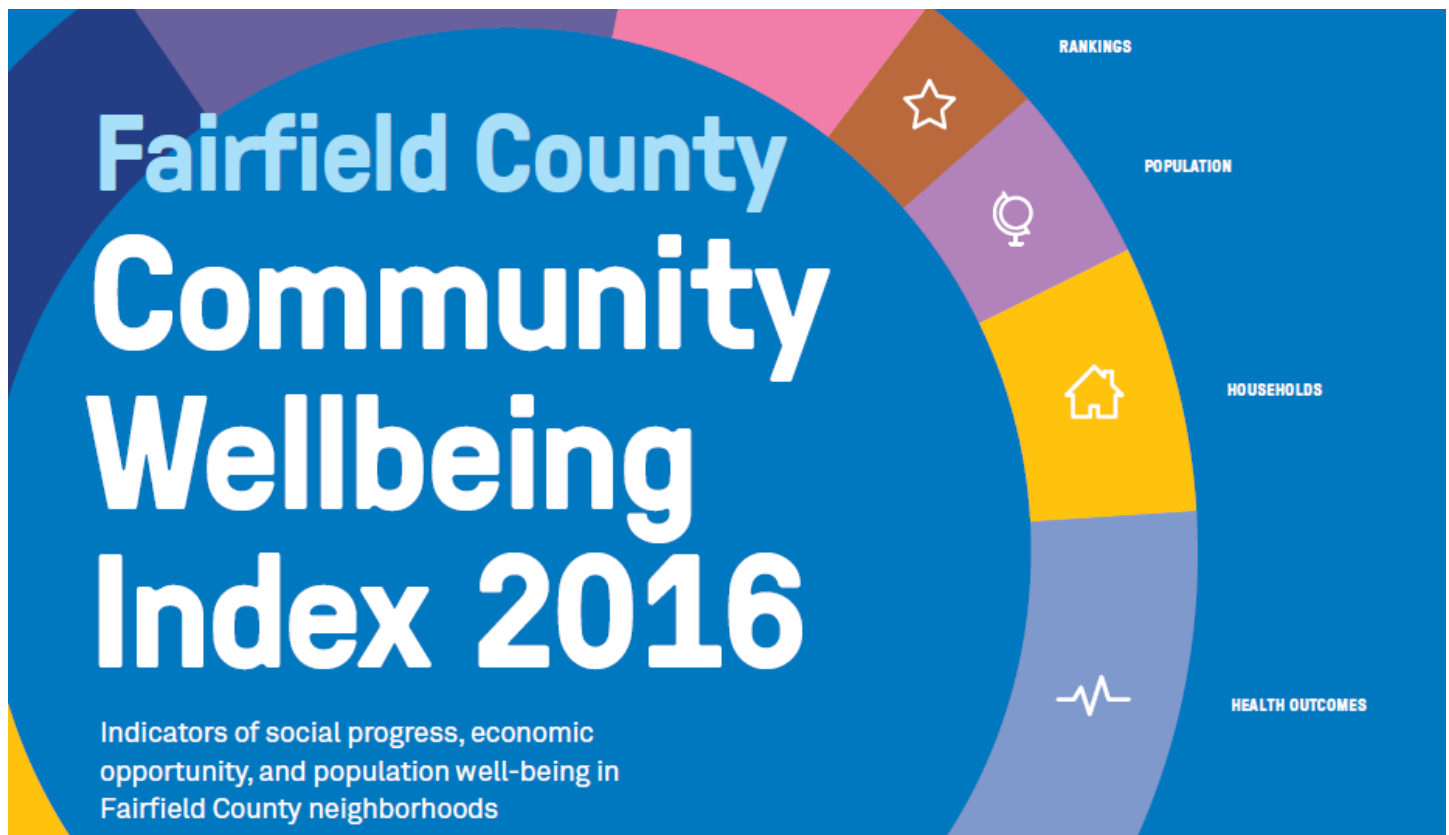
2016 Greater Bridgeport Region Bridgeport Hospital and St. Vincent's Medical Center Collaborative Community Health Assessment and Implementation Plan

By the

**Primary Care
Action Group**



This document is a special chapter of the



A core program of DataHaven, in partnership with Fairfield County's Community Foundation and a Community Health Needs Assessment for towns served by all Fairfield County hospitals including **Bridgeport Hospital** and **St. Vincent's Medical Center**



ABOUT THIS REPORT

This document is a special chapter of the **2016 Fairfield County Community Wellbeing Index**, a comprehensive report about Fairfield County and the towns within it. The Community Wellbeing Index was produced by DataHaven in partnership with Fairfield County's Community Foundation and many other regional partners, including the Primary Care Action Group (PCAG), a coalition serving towns in the Greater Bridgeport Region. The Community Wellbeing Index serves as a Community Health Needs Assessment for Fairfield County and the towns within it, including the six towns in the PCAG area (Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull). Topics covered in the Index include: demographic change, housing, early childhood education, K-12 education, economic opportunity, leading public health indicators, and civic and community life.

This chapter provides additional local detail of relevance to the Greater Bridgeport Region, including data points on the six towns that in some cases would not fit within the main Community Wellbeing Index. It also documents the process that PCAG used to conduct the regional health assessment and health improvement activities. You may find the full Index attached to this chapter, or posted on the DataHaven, Fairfield County's Community Foundation, Bridgeport Hospital, St. Vincent's Medical Center, or any of the town health department websites. The Community Health Needs Assessment and Community Health Improvement Plan were approved by the Board of Trustees for St. Vincent's Medical Center in June 2016 and the Board of Trustees for Bridgeport Hospital in June 2016.



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I. EXECUTIVE SUMMARY

INTRODUCTION

Understanding the current health status of the community is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups. To this end, the Primary Care Action Group (PCAG) comprised of Bridgeport Hospital, St. Vincent's Medical Center, local departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Bridgeport Region, as fully set forth in Appendix A – are leading a comprehensive regional Community Health Needs Assessment (CHNA) effort. This effort is comprised of two main elements:

- Assessment – identifies the health-related needs in the Greater Bridgeport area using primary and secondary data.
- Implementation Plan– determines and prioritizes the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the CHNA conducted from March 2015 – May 2016. During this process, the following goals were achieved: examined the current health status of the Greater Bridgeport region and compared rates to state indicators and goals; explored current health priorities among residents and key stakeholders; and identified community strengths, resources, and gaps in order to assist PCAG and community partners in establishing implementation strategies, programming, and top health priorities.

METHODS

PCAG adopted the Association for Community Health Improvement's (ACHI) Community Health Assessment Framework to guide the CHNA and to ensure that it meets the needs of the hospitals' Internal Revenue Service requirements and those of the local health departments pursuing voluntary accreditation through the Public Health Accreditation Board. Specifically, the CHNA defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health – from lifestyle behaviors to clinical care to social and economic factors to the physical environment. These social determinants of health framework guided the overarching process.

Data Collection Methods

Quantitative and qualitative data were collected and reviewed throughout the CHNA process. Secondary data sources included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, State of Connecticut Department of Public Health, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data included vital statistics based on birth and death records. In addition, PCAG partnered with DataHaven and, in part, sponsored the 2015 DataHaven Community Wellbeing Survey (CWS), hired Chanana Consulting to conduct focus groups in the Greater Bridgeport Region and worked with a student practicum team from the Yale School of Public Health with technical assistance from DataHaven to conduct and later analyze Key Informant Surveys.

KEY FINDINGS

The following section provides a brief overview of the key findings from the community health needs assessment for the Greater Bridgeport Region. This includes overall demographics, social and physical environment, health outcomes and findings as they relate to the top four health priorities that were selected for action planning at a regional level: Cardiovascular Disease and Diabetes; Healthy Lifestyles; Mental Health and Substance Abuse; and Access to Care. Complete findings from the DataHaven CWS are covered in the 2016 Fairfield County Community Wellbeing Index and detailed data by town are available in the survey crosstabs on the DataHaven website.

Demographics

Numerous factors are associated with the health of a community including what resources and services are available as well as who lives in the community. While individual characteristics such as age, gender, race, and ethnicity have an impact on people's health, the distribution of these characteristics across a community is also critically important and can affect the number and type of services and resources available.

- **Population.** The Greater Bridgeport Region has a population of 323,231. Bridgeport, Connecticut's largest city, comprises 45% of the region's population.
- **Age Distribution.** The median age of the area is 40.3 years, which is higher than the state as a whole, except for the City of Bridgeport. Bridgeport's median age is lower at 32.8 years.
- **Racial and Ethnic Diversity.** The towns in the region vary dramatically in terms of their racial and ethnic composition. The communities of Easton, Fairfield, Monroe and Trumbull are over 80% White and Stratford is over two-thirds White. By contrast, close to 80% of Bridgeport's population is non-White; Hispanics and African-American's each comprise more than one third of Bridgeport's residents.

Social and Physical Environment

Income and poverty are closely connected to health outcomes. A higher income makes it easier to live in a safe neighborhood with good schools and many recreational opportunities. Higher wage earners are better able to buy medical insurance and medical care, purchase nutritious foods, and obtain quality child care than those earning lower wages. Lower income communities have higher rates of asthma, diabetes, and heart disease. Those with lower incomes also generally experience lower life expectancies.

- **Income and Poverty.** There are wide gaps in Medium Household income rates within the Greater Bridgeport Region. The towns of Easton, Fairfield, Monroe, and Trumbull are affluent with median incomes substantially higher than national and state averages. Stratford, which has a long history as an industrial town, was described by residents as blue collar and middle class. Bridgeport has a high poverty rate and a lower median income than both state and national averages; it is among one of the poorest cities in the country.
- **Educational Attainment.** The proportion of residents with a college degree or higher in Easton, Fairfield, Monroe and Trumbull is greater than that of the state overall at 37%. Only 16% of Bridgeport adults have a college degree or higher, less than half the rate for the state; Stratford also falls below the state rate with only 31% of the residents having a college degree or higher.

Health Outcomes

Health outcomes and risk factors related to chronic disease, mental health and substance abuse, mortality and morbidity are covered in significant detail in the 2016 Fairfield County Community Wellbeing Index (CWS). These include:

- **Self-Reported Health Status.** Self-reported health status, which is a powerful predictor of future disability, hospitalization, and mortality, varies widely throughout the region by education and income level. Self-rated health is lower in Bridgeport than in other towns, especially after adjusting for differences in age.
- **Neighborhood Environments.** Perceived quality of society, which relates to neighborhood trust, safety, child-friendliness, perceptions of government services, and many other factors, are studied in-depth by the CWS. Once again, responses from Bridgeport residents were much less positive than those from the surrounding towns and responses are highly correlated to income levels with lower income households being less positive with quality of society.
- **Financial Stress.** The 2015 CWS contains several markers of financial stress, many of which are directly related to income levels. Across the board, positive levels of markers of financial stability — food security, housing security, transportation access, and financial comfort — are significantly higher in wealthier areas.
- **Health Priorities.**
 - **Cardiovascular Disease and Diabetes.** A direct outcome of health behaviors such as lack of exercise, lack of access to healthy food and tobacco use are related medical conditions and complications from obesity including high blood pressure, high cholesterol, diabetes, heart disease or heart attack. There is higher incidence of diabetes in Bridgeport, Monroe and Trumbull when compared to the rate for the Greater Bridgeport Region and the state overall. In addition, 26% to 32% of the population report having high blood pressure and/or hypertension.
 - **Healthy Lifestyles.** Obesity rates are rising in Connecticut and Bridgeport with more than one out of four adults classified as obese. The findings indicate that the prevalence of obesity in Bridgeport (36%) and Stratford (27%) is higher than the Connecticut rate (26%). On the contrary, smoking prevalence rates in Connecticut have decreased since 2000 and were at 15% in 2015. Smoking rates in Bridgeport and Stratford are higher than the state rate, while rates in the other Greater Bridgeport towns are lower. CWS data also indicate that over half of the current smokers in Greater Bridgeport (56%) have stopped smoking cigarettes for 24 or more hours because they were trying to quit, which is a positive indicator of potential future lower smoking rates.
 - **Mental Health and Substance Abuse.** The focus group findings, analysis of key informant surveys, and secondary data obtained from various sources including the Connecticut Health Information Management Exchange, a data repository for all hospital encounters, all support the inclusion of this priority area. There is a significant need in the community for mental health services, as nationally twenty percent of people in a given year will need some type of mental health support, and there is a gap of available local services. Data from the CWS find that a person's reported level of happiness and anxiety are directly correlated to income and education; adults who reported feeling happy ranged from a low of 67% in Bridgeport to a high of 82% in Easton, and these rates were directly correlated with income level. In addition, adults who do not have a high school degree were 3 times more likely to feel anxious as those who have completed college or additional education.

- **Access to Care.** Financial stress and lower socioeconomic status also have challenges related to access to medical care. Approximately 21% of Connecticut respondents indicated that they had postponed or delayed getting the medical care they thought they needed in the past 12 months; rates among residents in the Greater Bridgeport region are the same as the state at 21% and higher among Bridgeport residents at 24%. Although the majority of residents in the Greater Bridgeport region have health insurance (93%), rates are slightly lower among groups with either less educational achievement or lower earnings. In focus group discussions, it was determined that the type of insurance a person had was tied to issues around access to care and quality of care. Specifically, those with state insurance have limited providers, long wait times, and challenges with coverage for prescription medications, dental care and mental health services.

II. INTRODUCTION

A. OVERVIEW

Improving the health of a community is critical to ensuring the quality of life of its residents and fostering sustainability and future prosperity. Health is intertwined with multiple facets of our lives; where we work, live, learn, and play all have an impact on our health. Understanding the current health status of a community – and the multitude of factors that influence health – is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups.

To this end, the Primary Care Action Group (PCAG) – a coalition of two hospitals, five departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Bridgeport Region of Connecticut – is leading a comprehensive regional Community Health Needs Assessment (CHNA) effort. This effort is comprised of two main elements:

- Assessment – identifies the health-related needs in the Greater Bridgeport Area using primary and secondary data.
- Implementation Plan – determines and prioritizes the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the Community Health Needs Assessment conducted from March 2015 – May 2016. The Primary Care Action Group adopted the Association for Community Health Improvement's (ACHI) Community Health Assessment Framework (Figure 1) to guide the CHNA and to ensure that it meets the needs of the hospitals' Internal Revenue Service requirements and those of the local health departments pursuing voluntary accreditation through the Public Health Accreditation Board.

Figure 1: Association for Community Health Improvement Six Step Community Health Assessment Process





B. ADVISORY STRUCTURE AND PROCESS

The Community Health Needs Assessment was spearheaded, funded, and managed by the Primary Care Action Group, which includes Bridgeport Hospital, St. Vincent's Medical Center, City of Bridgeport Department of Health and Social Services, Fairfield Health Department, Monroe Health Department, Trumbull Health Department, Stratford Health Department, Optimus Healthcare, Southwest Community Health Center, AmeriCares Free Clinic of Bridgeport, LLC (see Appendix A for a full list of organizational members). The Primary Care Action Group was founded in 2003 with the mission to improve the health of the community. PCAG's vision is to work together as a coalition to identify, prioritize, and measurably improve the health of their community through health care prevention, education, and services. To develop a shared vision and plan for the community and help sustain lasting change, the PCAG assessment and planning process aimed to engage agencies, organizations, and residents in the area through participatory and collaborative approaches.

PCAG reached out to the larger community through communications and meetings to discuss the importance of this planning process. Additionally, the community was engaged in focus groups, key informant surveys, and DataHaven Community Wellbeing Survey during the comprehensive data collection effort of the community health needs assessment. Public awareness and dissemination of the CHNA findings and subsequent CHIP priorities and strategies will continue to be conducted via media and public events.

C. PURPOSE AND GEOGRAPHIC SCOPE

The Greater Bridgeport Community Health Needs Assessment was conducted to meet several overarching goals:

1. To examine the current health status of the Greater Bridgeport area (comprised of Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull)
2. To explore current health priorities – as well as emerging health concerns – among residents within the social context of their communities; and
3. To meet the legal requirement of Bridgeport Hospital and St. Vincent's Medical Center to conduct a community health needs assessment at least once every three (3) years and to adopt a written implementation strategy to meet the community health needs identified through the community health needs assessment; and
4. To meet voluntary health department Public Health Accreditation Board requirements.

To define community for CHNA purposes, this Greater Bridgeport Community Health Needs Assessment uses a geographic approach focusing on six towns within Fairfield County, CT: Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull (Figure 2). These communities are served by both Bridgeport Hospital and St. Vincent's Medical Center and do not overlap with CHNA areas identified by other acute care hospitals and/or collaborations. Upon defining the geographic area and population served in Greater Bridgeport, PCAG was diligent to ensure that no groups, especially minority, low-income or medically under-served, were excluded.

Figure 2: Map of Community Served - Greater Bridgeport Area, Connecticut



III. METHODS

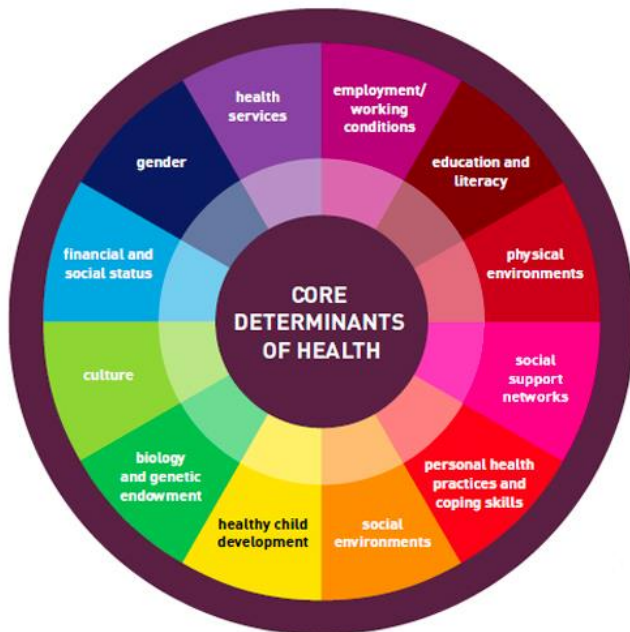
The following section describes the process and methods used to conduct the Community Health Needs Assessment including what qualitative and quantitative data was compiled and how it was analyzed, as well as a description of the broader lens used to guide the process. Specifically, the Community Health Needs Assessment defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health – from lifestyle behaviors to clinical care to social and economic factors to the physical environment. The beginning of this section discusses the larger social determinants of health framework which helped guide this overarching process.

A. SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

It is important to recognize that multiple factors have an impact on health and that there is a dynamic relationship between real people and their lived environments. Where we are born, grow, live, work, and age – from the environment in the womb to our community environment later in life – and the interconnections among these factors are critical to consider. That is to say, health outcomes are influenced by more than just an individual's genetic code and, in fact, zip code is more predictive as influenced by lifestyle behaviors and upstream factors such as income, education, employment and quality of housing stock. The social determinants framework addresses the distribution of wellness and illness among a population.

The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors such as education and literacy and physical environments (Figure 3). This report as well as the 2016 Fairfield County Community Index provides information on many of these factors, as well as reviews key health outcomes.

Figure 3: Social Determinants of Health Framework





B. DATA COLLECTION METHODS – COMMUNITY INPUT

1. QUANTITATIVE DATA

a) Reviewing Existing Secondary Data

The Greater Bridgeport Community Health Needs Assessment was built off of previous efforts in the Greater Bridgeport Region, such as the 2013 Community Health Needs Assessment and resulting Community Health Improvement Plan that has been guiding the direction of the Primary Care Action Group over the past three years. In addition, the Community Health Needs Assessment utilized sources of secondary data including, but not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, State of Connecticut Department of Public Health, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data included vital statistics based on birth and death records.

b) 2015 Community Wellbeing Survey

The Primary Care Action Group partnered with DataHaven, whose mission is to improve quality of life by collecting, interpreting and sharing public data for effective decision-making, on the 2015 Community Wellbeing Survey. The Community Wellbeing Survey assisted the Primary Care Action Group to gather quantitative or primary data that were not provided by secondary sources and to understand public perceptions around health, social determinant, and other issues. The Wellbeing Survey was conducted from April to October 2015 by the Siena College Research Institute. The Survey was administered by randomly-selected land and cell phones and completed in-depth interviews with 16,219 adults statewide including 1,850 adults living in Bridgeport, Easton, Fairfield, Monroe, Stratford and Trumbull. The survey was designed by DataHaven and the Siena College Research Institute, in consultation with local, state, and national experts including members of PCAG. Interviews were weighted to be statistically representative of adults in each sub-region. Surveys were administered in both English and Spanish and zip codes were targeted to supplement samples of hard-to-reach populations.

The survey has created information that was previously unavailable at a local level from any other source and cross sector analysis provides information on neighborhood quality, happiness, housing, transportation, health, economic security, workforce development, and other topics. Findings from the Community Wellbeing Survey are primarily covered within the 2016 Fairfield County Community Wellbeing Index. Detailed data by town are available in the survey crosstabs on the DataHaven website.

2. QUALITATIVE DATA

a) Focus Groups

In December 2015 and January 2016, seven focus groups engaging a total of 73 individuals were conducted by Chanana Consulting in the Greater Bridgeport Region. The goals of the focus groups were to determine perceptions of health strengths and needs in the Greater Bridgeport Region; to identify gaps, challenges and opportunities for addressing community needs more effectively; and to explore how these issues can be addressed in the future. Working with PCAG, groups having a disproportionate burden of health issues were identified (i.e. lower income adults, people with limited English proficiency or Latino adults) as a priority to include in the focus groups. PCAG members identified specific groups and/or organizations that fulfilled these criteria, and the consultant facilitated the following groups: residents from an urban public housing authority complex; residents from a suburban senior public housing authority complex; members of a Hispanic church; parish nurses; parents of a lower-income suburban school; seniors from a urban/suburban senior center; and community members of an urban/suburban community center.

In addition, the consultant maintained efforts to include a geographical sample of residents from the six towns and cities that make up the Greater Bridgeport CHNA region.

b) Key Informant Surveys

The Community Health Needs Assessment was initiated in 2015 with the online key informant survey administered and analyzed by a student practicum team at the Yale School of Public Health with technical assistance provided by DataHaven. The online survey was administered to community leaders and service providers in the Greater Bridgeport area using Qualtrics, an online survey tool. Members of PCAG identified 181 key informants between the two groups and had 64 responses in total. The Health and Human Services group included hospital administrators, state and local health departments, physicians, nurses, social service agency leaders and providers, community planning organizations, family centers and youth services, elderly services, supportive housing providers, primary care centers and recreation facilities. The Government and Community Leaders group included state and local elected officials, police and fire departments, library directors, clergy, other government agency heads, school principals, after school program providers, arts organizations, journalists, community advocacy organizations, neighborhood association leaders, chambers of commerce and community service organizations. Surveys were designed to better understand the health needs of the Greater Bridgeport Region and included questions on community health initiatives, health related problems, barriers to good health, health services, and current outlooks.

3. ANALYSES

The secondary data and qualitative or primary data from the Community Wellbeing Survey, focus groups, and key informant surveys were synthesized and integrated into this report.

4. LIMITATIONS

As with all research efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Data based on self-reports should be interpreted with some caution. In some instances, respondents may over or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately but remember incorrectly. In some surveys recalling and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys, particularly those using random sampling methods, benefit from large sample sizes and repeated administrations, enabling comparison overtime.

While focus groups and key informant surveys conducted for this assessment provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. It is also important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

IV. FINDINGS

A. DEMOGRAPHICS

This section provides a brief overview of the population of the Greater Bridgeport Region. For a more detailed review of regional demographics, please refer to the 2016 Fairfield County Community Index. Numerous factors are associated with the health of a community including what resources and services are available as well as who lives in the community. While individual characteristics such as age, gender, race, and the ethnicity have an impact on people's health, the distribution of these characteristics across a community is also critically important and can affect the number and type of services and resources available. The data shows that the Greater Bridgeport region is slightly younger than the state. Younger residents tend to live in urban areas like Bridgeport, while older residents live in the wealthier suburbs. Bridgeport is a very diverse community, with the majority of residents being Black or Hispanic, while the suburbs are mostly White non-Hispanic.

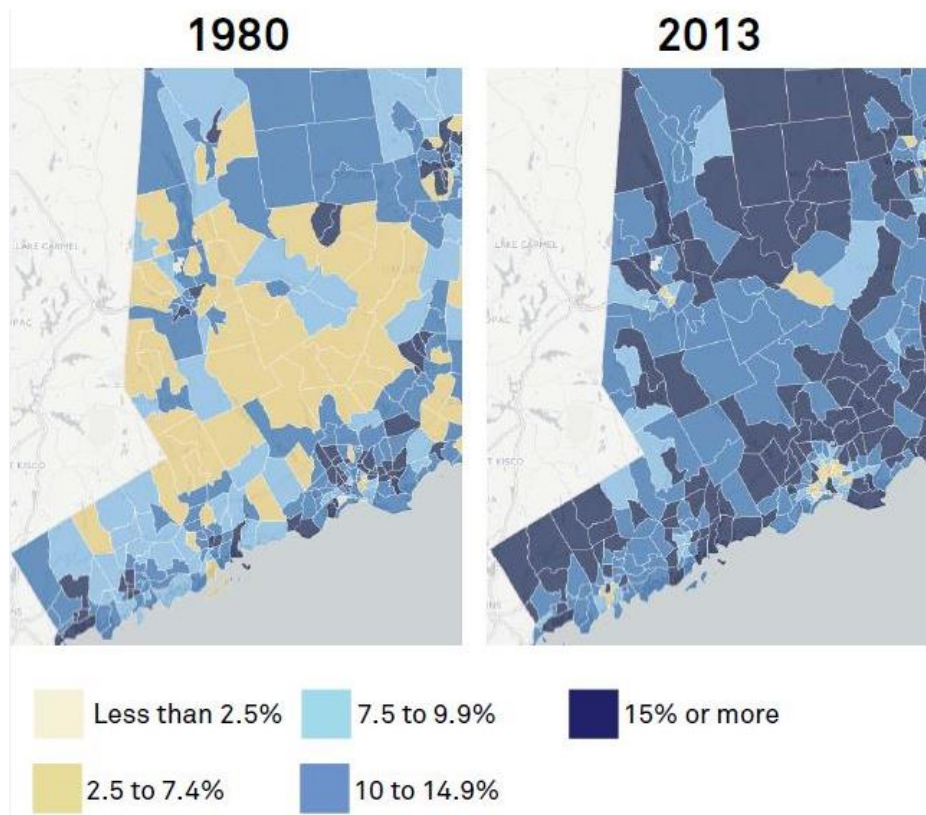
Table 1: Population and Demographic Composition - 2010-2014 American Community Survey

	Population	Age	White Not-Hispanic	Black Not-Hispanic	Hispanic	Other Not-Hispanic
Connecticut	3,592,053	40.3	70%	10%	14%	6%
Fairfield County	934,215	39.6	65%	10%	18%	7%
Greater Bridgeport Region	323,231	37.8	53%	18%	22%	6%
Bridgeport	146,680	32.3	21%	34%	39%	6%
Easton	7,593	46.9	90%	1%	6%	4%
Fairfield	60,678	40.7	86%	1%	5%	7%
Monroe	19,744	43.0	90%	1%	5%	5%
Stratford	52,092	43.0	66%	14%	14%	5%
Trumbull	36,444	43.4	83%	2%	8%	6%
Bridgeport Neighborhood Statistical Areas						
Bridgeport East Side and East End	22,510	28.5	4%	39%	53%	4%
Central Bridgeport	81,953	32.8	18%	34%	41%	7%
Other Bridgeport	42,217	35.1	37%	32%	26%	5%
Source: DataHaven analysis of 2010-2014 American Community Survey, via census.gov and Census API						

Age Distribution

The population of Fairfield County is aging, particularly within suburban communities, and is projected to age rapidly over the coming decades. Figure 4 shows this aging trend by comparing the percent of population that was age 65 or more in 1980 versus 2013. Currently, median age varies widely by town, from 33 in Bridgeport to 40 in Fairfield, and 42-45 in the other four towns in the PCAG region.

Figure 4: Secondary Data – Population Age 65 and Over



Source: US Census, Neighborhood Change Database, and CT State Data Center. Maps posted on DataHaven website

B. SOCIAL AND PHYSICAL ENVIRONMENT

Income and poverty are closely connected to health outcomes. A higher income makes it easier to live in a safe neighborhood with good schools and many recreational opportunities. Higher wage earners are better able to buy medical insurance and medical care, purchase nutritious foods, and obtain quality child care than those earning lower wages. Lower income communities have higher rates of asthma, diabetes, and heart disease. Populations with lower incomes also generally experience lower life expectancies.

Table 2: Key Socioeconomic Indicators - 2010-2014 American Community Survey

	Bachelor's degree or higher (age >25)	Commute time >30 min	Preschool enrollment rate, age 3-4	Disconnected Youth, age 16-19	Housing: Percent severely cost-burdened	Median Household Income	Low income rate among children age 0-17
Connecticut	37%	34%	64%	6%	18%	\$69,899	30%
Fairfield County	45%	38%	69%	6%	20%	\$83,163	26%
Greater Bridgeport Region	34%	40%	69%	9%	23%	\$73,929	38%
Bridgeport	16%	38%	62%	14%	29%	\$41,204	65%
Easton	58%	57%	86%	0%	22%	\$132,000	5%
Fairfield	62%	44%	78%	5%	15%	\$120,082	10%
Monroe	50%	45%	90%	2%	17%	\$108,688	17%
Stratford	31%	38%	75%	9%	21%	\$66,451	27%
Trumbull	51%	38%	74%	1%	16%	\$108,554	6%
Bridgeport Neighborhood Statistical Areas							
Bridgeport East Side and East End	7%	34%	59%	29%	38%	\$31,723	79%
Central Bridgeport	15%	39%	59%	11%	30%	\$36,143	68%
Other Bridgeport	23%	38%	75%	7%	23%	\$59,987	47%

Source: DataHaven analysis of 2010-2014 American Community Survey, via census.gov and Census API

Income

Though the economic status of the PCAG region as a whole is high, household income levels are significantly lower in Bridgeport and Stratford when compared to surrounding towns and to Fairfield County. In particular, the central area of Bridgeport has very low income levels by national and state standards (median household incomes of <\$35,000 per year are widespread), and is designated as an area of concentrated poverty. Sections of Central Bridgeport, and the East Side and East End in particular, have similar or higher levels of economic distress as some of the most disadvantaged zip codes within other urban core cities, particularly certain sections of Waterbury and Hartford, according to the 2016 Distressed Communities Index.

C. SECONDARY DATA

Chronic diseases are a major concern, including related self-reported risk factors like smoking and obesity, which are measured in the 2015 Community Wellbeing Survey. Secondary data shows that cancer and heart disease are leading causes of death throughout the towns by a wide margin. However, other issues such as stroke, lung disease, infant mortality, drug use, accidents, suicide, and homicide also contribute to higher mortality rates in some areas, particularly when prematurity of death (deaths prior to age 75) is taken into account.

Towns vary greatly according to age and economic status. These factors affect the burden and types of health conditions that are of concern in these communities. Areas which are older in average age have a greater burden of age-related illnesses such as cancer and Alzheimer's.

Bridgeport is seeing the combined effects of economically-distressed neighborhoods, lower socioeconomic status, older housing, and a younger population, which relate to greater numbers of adverse birth outcomes, violence, childhood asthma, lead poisoning, and other issues. Chronic disease – especially heart disease – impacts populations in Bridgeport's distressed neighborhoods at a younger age. Additionally, lower-income areas see particularly greater impacts from illnesses such as diabetes and renal/kidney disease that are considered to be more preventable, especially among some of the younger populations that live in these areas.

Mental health is an ongoing concern, as it overlaps with many of the other health issues. As mentioned above, drug use and overdose (generally included within accidents) is a leading cause of premature mortality.

Differences in Mortality Rates

Like Connecticut, mortality rates are declining in most towns since 2003-2007. Yet large differences exist in mortality rates, with Bridgeport in particular having elevated rates of all-cause mortality and of infant mortality. These measures are considered markers of overall population health.

All-cause mortality (Table 3):

- Bridgeport had significantly higher mortality rates than both the state and the county. Stratford had significantly higher mortality rates than the county.
- Easton, Fairfield, Monroe, and Trumbull have mortality rates that are significantly lower than the state.
- Bridgeport, Monroe, Stratford, and Trumbull had significantly lower mortality rates in 2008-2012 than in 2003-2007.

Table 3: Greater Bridgeport Area Age Adjusted Mortality Rates per 100,000 by Town

Bridgeport Area						
Age Adjusted Mortality Rates per 100,000 by town						
Town	cause of death	# deaths 2003-2007	AAMR 2003-2007	# deaths 2008-2012	AAMR 2008-2012	Significant change?
BRIDGEPORT	All	5530	819	4778	732	Yes
EASTON	All	198	550	248	532	
FAIRFIELD	All	2559	587	2457	565	
MONROE	All	589	732	609	575	Yes
STRATFORD	All	2865	751	2647	672	Yes
TRUMBULL	All	1700	652	1773	562	Yes

Source: DataHaven analysis of CTDPH data

TABLE KEY: Red shading is statistically worse than the state, yellow is the same as the state, green is statistically better than the state

Infant Mortality Rate and Fetal Infant Mortality Review (Table 4):

- All of the five towns saw some decreases in Infant Mortality Rate with the exception of Trumbull, which increased from 2.7 to 5.3. Bridgeport is the highest at 8.8 followed by Fairfield at 6.8 per 1,000.
- Though there have been decreases in Fetal Infant and Mortality Review in Bridgeport, Fairfield, Monroe, and Stratford, an increase has occurred in Easton and Trumbull.

Table 4: Greater Bridgeport Area Infant Mortality Rates by Town

Infant Mortality by Town 2003-2013				
	2003-2007		2008-2013	
town	IMR_per_1000	FIMR_per_1000	IMR_per_1000	FIMR_per_1000
Bridgeport	8.8	16.8	7.0	15.5
Easton	5.6	8.3	3.7	10.9
Fairfield	6.8	9.1	1.6	4.1
Monroe	2.1	6.3	1.2	4.6
Stratford	5.7	10.6	3.5	8.7
Trumbull	2.7	5.9	5.3	6.5

Source: DataHaven analysis of CTDPH data

TABLE KEY: Yellow shading is statistically the same as the state, green is statistically better than the state

Table 5 illustrates significant change in mortality rates compared to the State of Connecticut and between the two most recent time period data was collected. These issues are covered in more detail in the 2016 Fairfield County Community Wellbeing Index.

Table 5: Mortality Rates All-Cause and Other Cause, Significance Compared to Connecticut and Fairfield County, Change from 2003-2007 to 2008-2012 (↑ = indicates significant higher mortality rate; ↓ = indicates significant lower mortality rate; and - = indicates no significant change)

Source: DataHaven analysis of CTDPH data

	Bridgeport	Easton	Fairfield	Monroe	Stratford	Trumbull
All-Cause Mortality						
CT	↑	↓	↓	↓	-	↓
Change from 2003-07 to 2008-12	↓	-	-	↓	↓	↓
Heart Disease						
CT	↑	↓	↓	-	-	-
Change from 2003-07 to 2008-12	↓	-	-	↓	↓	↓
Cancer						
CT	-	-	↓	-	-	↓
Change from 2003-07 to 2008-12	↓	-	-	↓	↓	-
Stroke						
CT	↑	-	-	-	-	↓
Change from 2003-07 to 2008-12	↓	-	-	-	-	↓
Accident						
CT	-	-	↓	-	-	↓
Change from 2003-07 to 2008-12	-	-	-	-	-	-
Lung Disease/ Chronic Lower Respiratory Disease						
CT	↓	-	↓	-	-	↓
Change from 2003-07 to 2008-12	↓	-	-	-	-	-
Diabetes						
CT	↑	-	-	-	-	↓
Change from 2003-07 to 2008-12	-	-	-	-	-	-
Kidney Disease						
CT	↑	-	↓	-	-	↓
Change from 2003-07 to 2008-12	-	-	-	-	-	-
Suicide						
CT	↓	-	-	-	-	-
Change from 2003-07 to 2008-12	-	-	-	-	-	-
Homicide						
CT	↑	-	-	-	-	-
Change from 2003-07 to 2008-12	-	-	-	-	-	-
Drugs						
CT	-	-	↓	-	-	-
Change from 2003-07 to 2008-12	↓	-	-	-	-	-
Alcohol						
CT	-	-	-	-	-	-
Change from 2003-07 to 2008-12	-	-	-	-	-	-

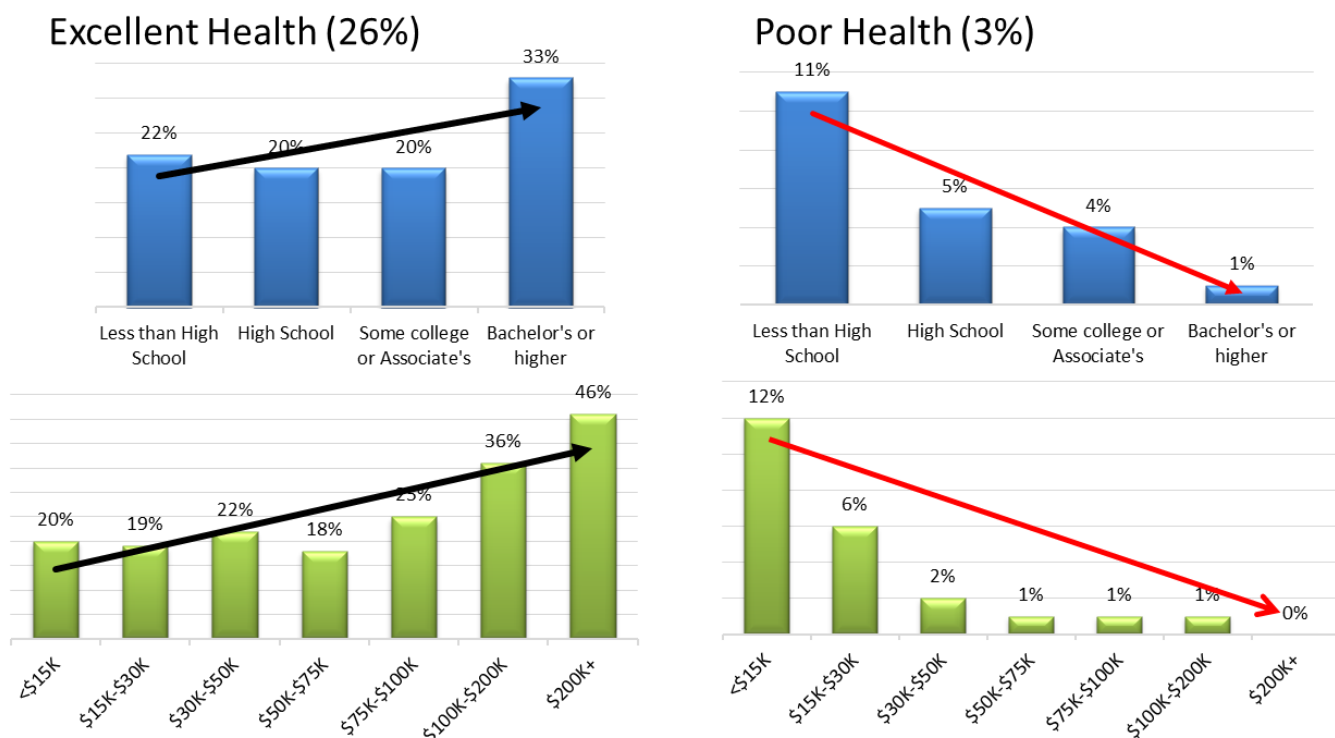
D. 2015 DATAHAVEN COMMUNITY WELLBEING SURVEY: HEALTH OUTCOMES

Findings from the 2015 DataHaven Community Wellbeing Survey are covered in detail within the 2016 Fairfield County Community Index. The following is a summary of findings of high relevance to the Primary Care Action Group.

Self-Reported Health Status

Self-reported health status (Figure 5), is a powerful predictor of future disability, hospitalization, and mortality, varies widely throughout the region by education and income level. Self-rated health is lower in Bridgeport than in other towns, especially after adjusting for differences in age. The 2015 DataHaven Community Wellbeing Survey question reads as follows: “How would you rate your overall health: would you say your health is excellent, very good, good, fair or poor?” In the Greater Bridgeport Region, 26% of adult respondents indicated that they were in “excellent” health and 3% that they were in “poor” health. However, wide gaps emerge when results are analyzed by education level or by income (Figure 5). Generally, higher education levels and higher income were associated with better self-reported health.

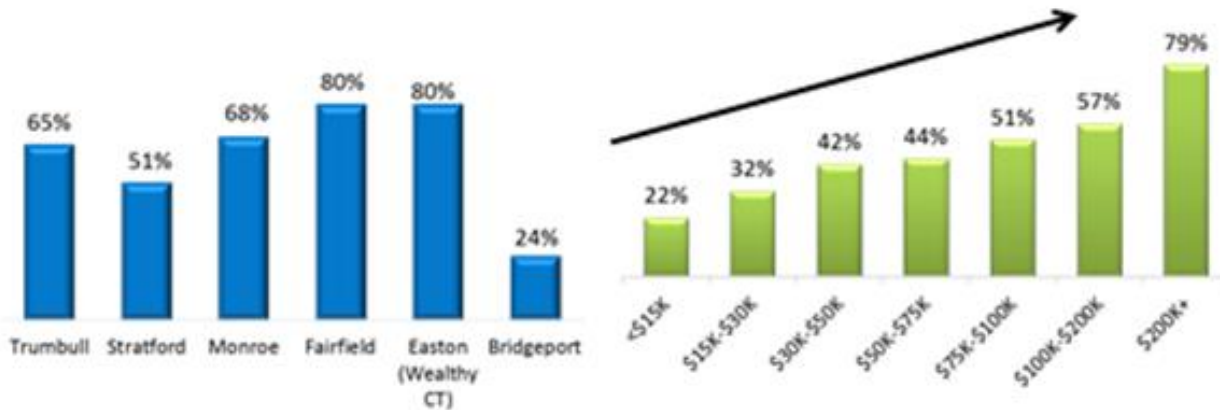
Figure 5: Greater Bridgeport Region Self-Reported Health Status by Education and Income (% of Adults)



Neighborhood Environments

Perceived quality of society, which relates to neighborhood trust safety, child-friendliness, perceptions of government services, and many other factors, are studied in-depth by the survey. These perceptions vary significantly by income level. As shown in Figure 6, residents in Fairfield and Easton (80%) where there is a higher average household income are significantly more likely to trust their neighbors than residents of Bridgeport (24%) where there is a lower average household income. The second graph shows the correlation by income level.

Figure 6: Greater Bridgeport Region Neighborhood Trust by Town and Income (% of Adults)

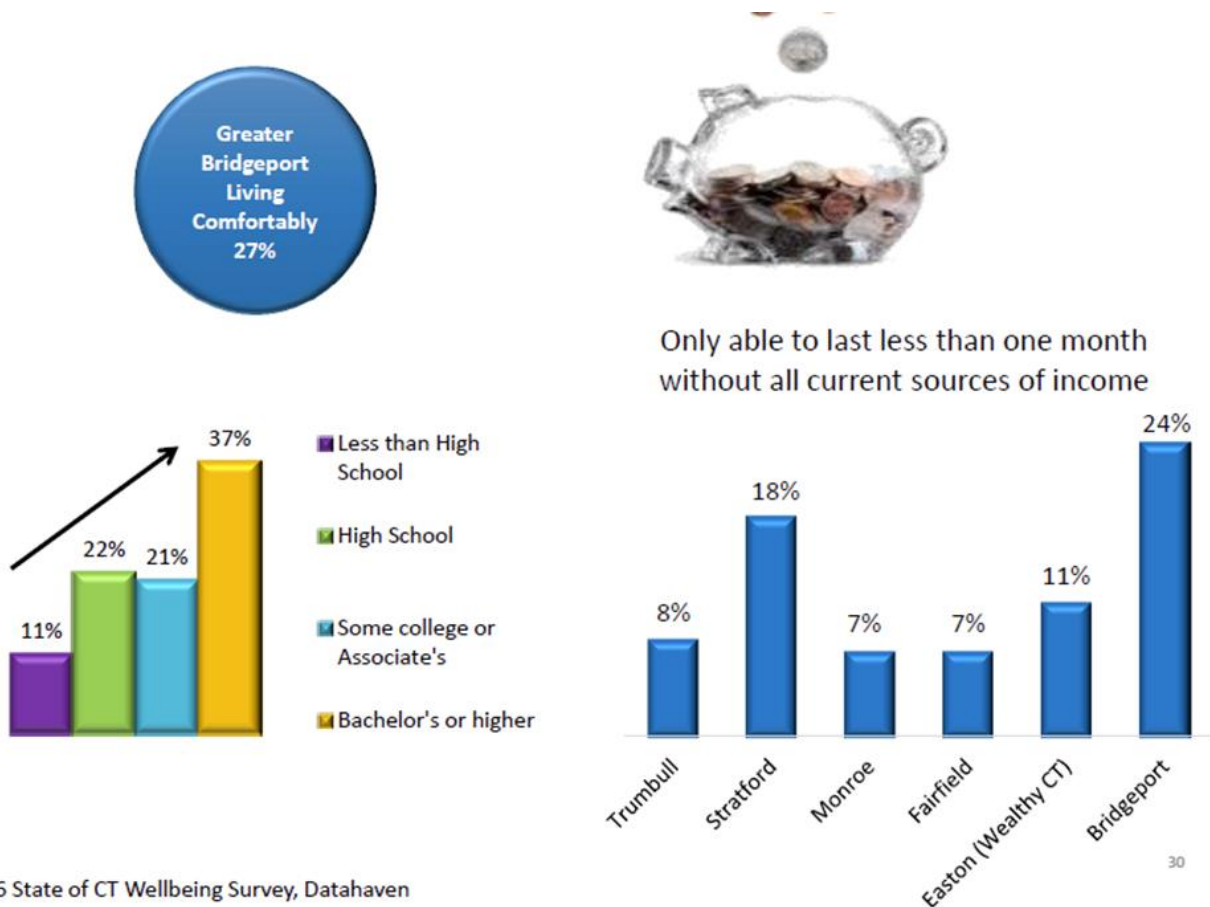


Source: 2016 State of CT Wellbeing Survey, Datahaven

Financial Stress

The 2015 Community Wellbeing Survey contains many markers of financial stress (Figure 7), many of which are directly related to income levels. Across the board, positive levels of food security, housing security, banking access, transportation access, and financial comfort are significantly higher in wealthy towns such as Fairfield and Monroe. Overall in Greater Bridgeport, 27% of adult respondents indicated that they are living comfortably, and as seen in the left hand graph below, those that are living comfortably are more likely to be educated. In terms of financial comfort, that also ties to income levels, as there were 24% of people in Bridgeport (lower average incomes) who would only be able to live less than a month if they lost all their current sources of income versus only 7% of people in that situation in Fairfield. This question indicates people who are likely living paycheck to paycheck.

Figure 7: Greater Bridgeport Region Financial Stress by Education and by Town (% of adults)

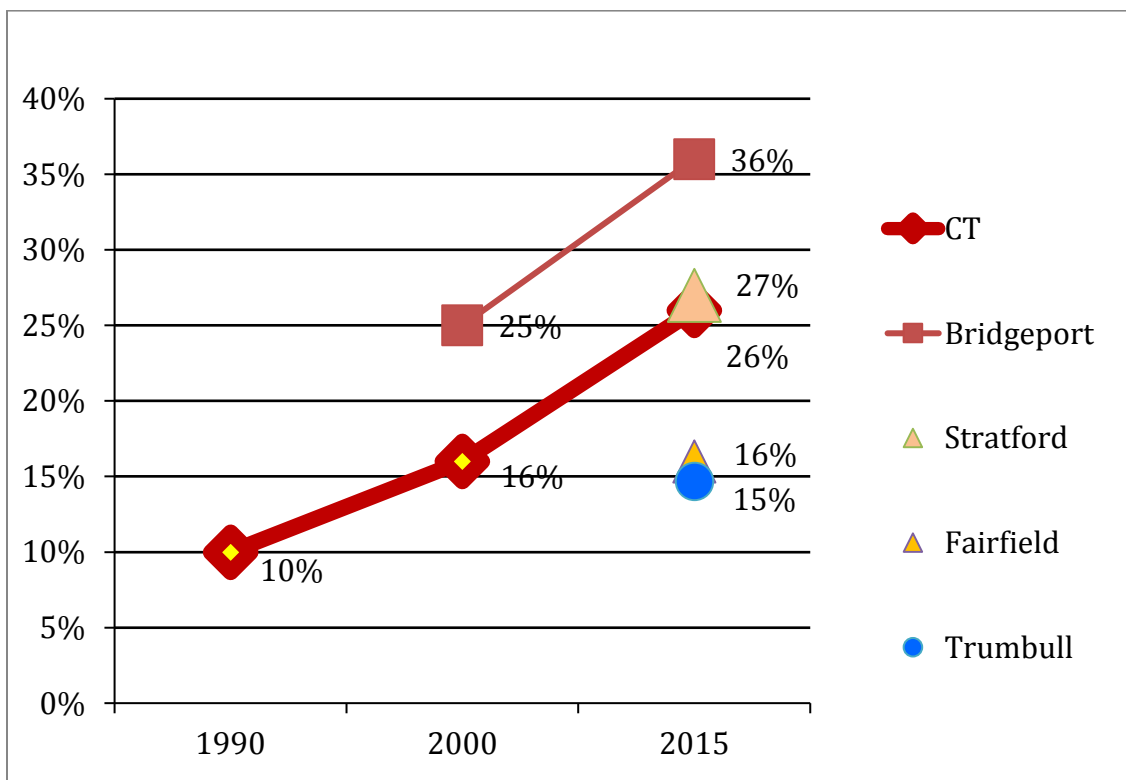


Related Health Behaviors and Outcomes

Although detailed data on health behaviors and outcomes are presented in detail in the 2016 Fairfield County Community Index, in order to put indicators including self-reported overall health status, neighborhood trust, safety and financial stress in context, some key health related areas are also covered here.

Obesity Prevalence (Figure 8) was measured using self-reported height and weight to calculate the body mass index (BMI) for adult respondents of the DataHaven Community Wellbeing Survey. The findings indicate that the prevalence of obesity in Bridgeport (36%) and Stratford (27%) is higher than in Connecticut (26%). Of concern is that overall obesity rates are rising.

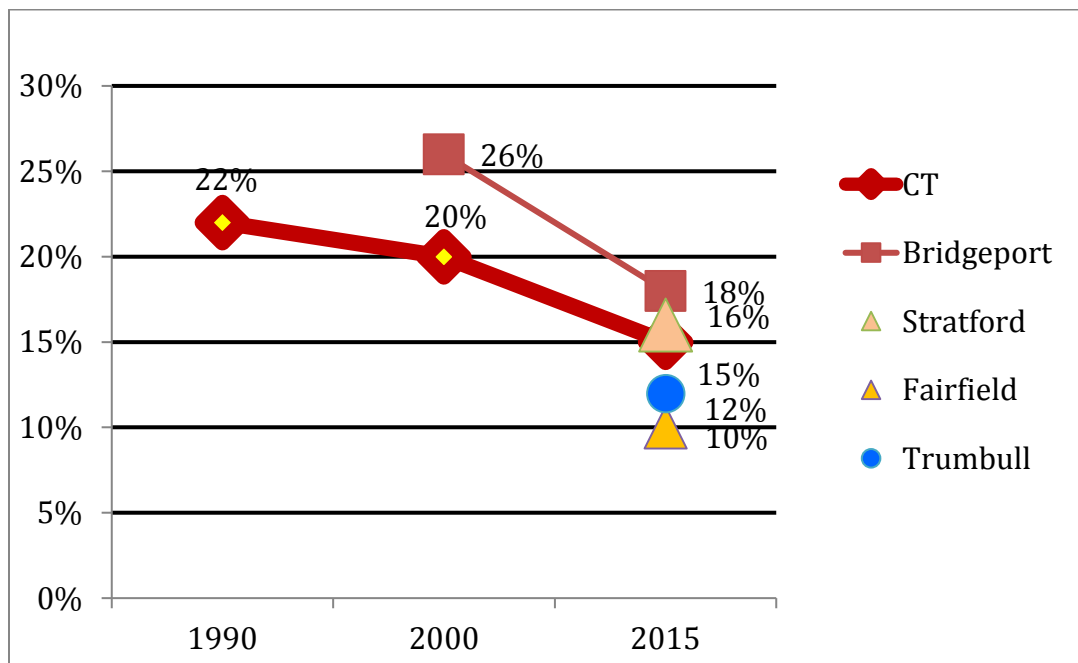
Figure 8: Obesity Prevalence, Trends in Adults 18+



Sources: 2015 DataHaven Community Wellbeing Survey (2015); 2007 CT Health Data Scan. Historical data may be directly compared to 2015 data. Obese is defined as BMI > 30.

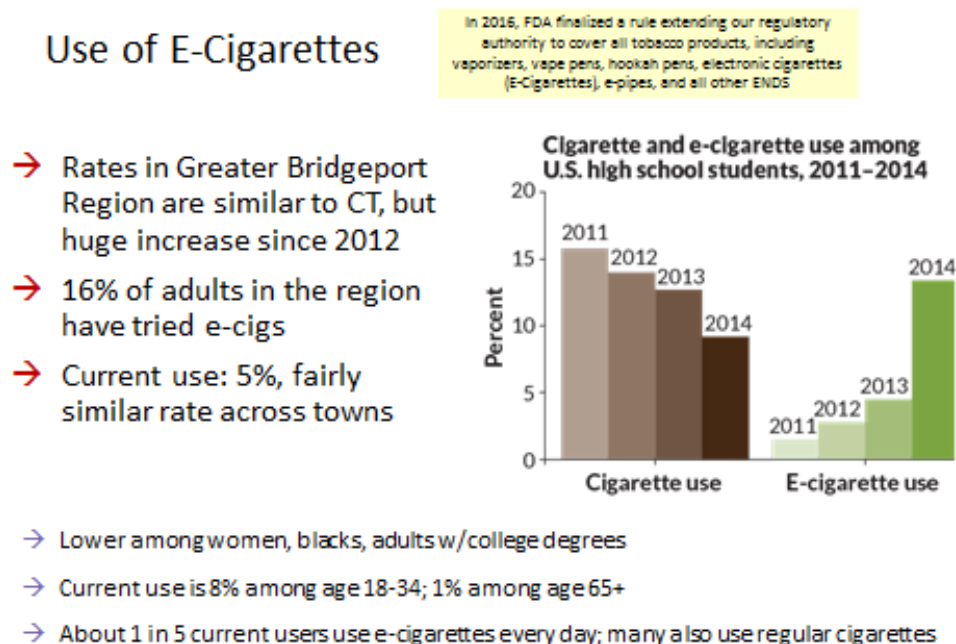
Figure 9 illustrates the smoking prevalence in Connecticut and the Greater Bridgeport Region – rates across the state have decreased since 2000 and were at 15% in 2015. Rates in Bridgeport (18%) and Stratford (16%) are slightly higher than the state. Survey data also indicates that over half of the current smokers in Greater Bridgeport (56%) have stopped smoking cigarettes for 24 or more hours because they were trying to quit. This is good news for public health when considering the Stages of Change (transtheoretical model), which assesses an individual's readiness to act on a new healthier behavior, meaning that with support the prevalence of smoking may be driven down even further across the Greater Bridgeport region. That said, the prevalence of e-cigarettes has increased (Figure 10). However that may start to stabilize due to the U.S. Food and Drug Administration (FDA) finalizing a rule in 2016 extending regulatory authority to cover all tobacco products including vaporizers, vape pens, hookah pens, electronic cigarettes, etc.

Figure 9: Smoking Prevalence, Trends in Adults 18+



Sources: 2015 DataHaven Community Wellbeing Survey (2015); 2007 CT Health Data Scan; 2011 American Lung Association Trends in Tobacco Use. Historical data may be directly compared.

Figure 10: Use of E-Cigarettes



Source of chart: Science News (2013), available at <https://www.sciencenews.org/article/e-cigarettes-proving-be-danger-teens>, DataHaven

A direct outcome of health behaviors such as lack of exercise, lack of access to healthy food and tobacco use are related to medical conditions and complications from obesity such as high blood pressure, high cholesterol, diabetes, heart disease or heart attack, and to some extent asthma. Table 6 shows the percent of adults who responded that they had been told by a doctor or health professional that they have a particular medical condition. Though the rates are similar across the region, there is higher incidence of asthma in Bridgeport and Stratford and diabetes in Bridgeport and Trumbull. In addition, 26% to 32% of the population has high blood pressure or hypertension.

Table 6: Greater Bridgeport Medical Conditions (% of adults)

	CT	Fairfield County	Greater Bridgeport	Bridgeport	Fairfield	Monroe	Stratford	Trumbull
High blood pressure/ Hypertension	28%	24%	28%	28%	26%	29%	32%	28%
High cholesterol	23%	21%	22%	20%	21%	15%	22%	32%
Diabetes	9%	7%	9%	12%	7%	10%	8%	11%
Heart disease/ Heart attack	5%	5%	5%	5%	5%	6%	5%	7%
Asthma	13%	11%	12%	15%	7%	7%	16%	7%
Stroke	2%	2%	2%	3%	2%	3%	3%	4%

Source: 2015 DataHaven Wellbeing Survey

Access to Care

Financial stress and lower socioeconomic status may also have challenges related to access to medical care for various reasons including physicians or other providers not accepting insurance, unable to get an appointment soon enough and not being able to get to the doctor's office or clinic when it was open (Table 7). Approximately 21% of Connecticut respondents indicated that they had postponed or delayed getting the medical care they thought they needed in the past 12 months; rates among residents in the Greater Bridgeport region are the same as the state at 21% and slightly higher among Bridgeport residents at 24%.

**Table 7: Greater Bridgeport Access to Medicare Care –
Reasons for postponing or not getting care in the past 12 months**

Percent of all adults 18+	PCAG 21%	Bridgeport 24%	Fairfield 15%	Monroe 18%	Stratford 21%	Trumbull 14%
Due to worries about cost	48%	48%	54%	73%	39%	39%
Too busy with work or other commitments	53%	51%	43%	66%	59%	57%
Did not think problem was serious enough	42%	36%	59%	49%	46%	52%
Health plan would not pay for treatment	28%	29%	15%	55%	24%	38%
Couldn't get appointment soon enough	26%	30%	17%	19%	17%	22%
Couldn't get there when office/clinic was open	24%	27%	16%	16%	19%	22%
Doctor/hospital wouldn't accept health insurance	15%	18%	17%	15%	8%	8%

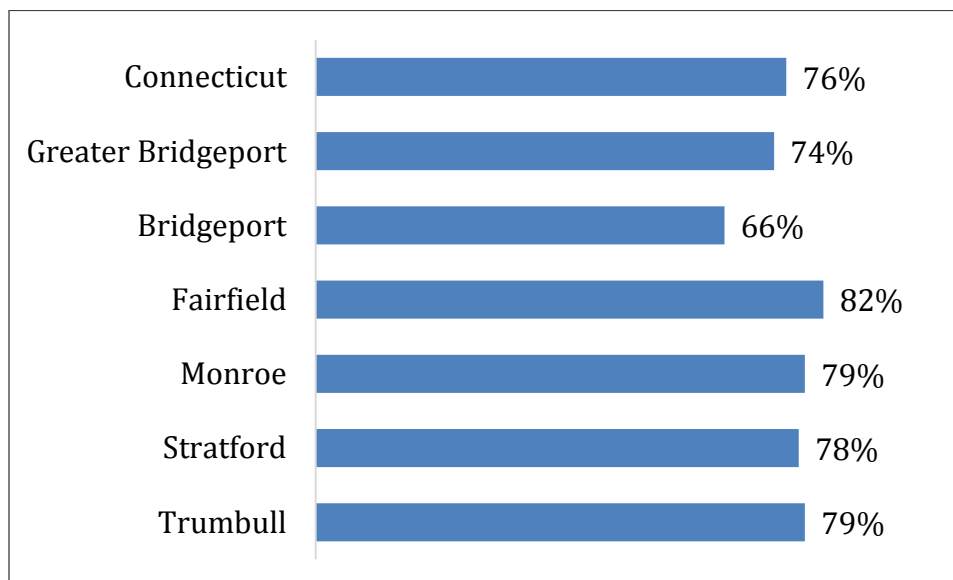
Positive news is that the majority of residents in the Greater Bridgeport Region have health insurance (93%). However, rates are slightly lower among groups with those that have less educational achievement, lower earnings, or are young adults:

- 18-34 year olds (89%)
- Respondents earning < \$15 K (87%)
- Less than High School Education (77%)

In focus group discussions, it was determined that the type of insurance a person had was tied to issues around access to care and quality of care. Specifically, those with state insurance have limited providers, long wait times, and challenges with coverage for prescription medications, dental care and mental health services.

Access to dental care was also mentioned at most focus group discussions, specifically, the high cost of dental care and the limited number of providers for adults on Medicaid and Medicare. Figure 11 illustrates that 74% of adults in the Greater Bridgeport area have been to a dentist in the past year, with rates ranging from a low of 66% in Bridgeport to a high of 82% in Fairfield.

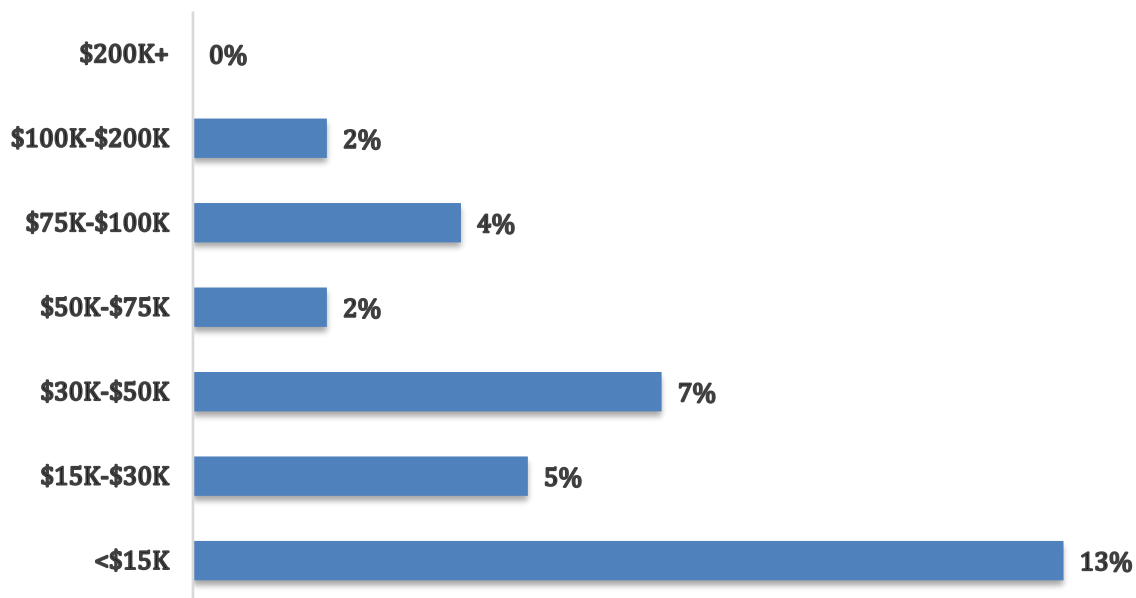
Figure 11: Percent of Adults Seen by a Dentist in the Past Year



Source: 2015 DataHaven Wellbeing Index

In terms of using an Emergency Room for care, higher income respondents were less likely to use the hospital emergency department for care (Figure 12). Respondents earning less than \$15,000 per year were six times more likely to use a hospital emergency department for care than someone earning \$100,000 to \$200,000 per year.

Figure 12: Care in Hospital Emergency Department in Past year (% of adults)



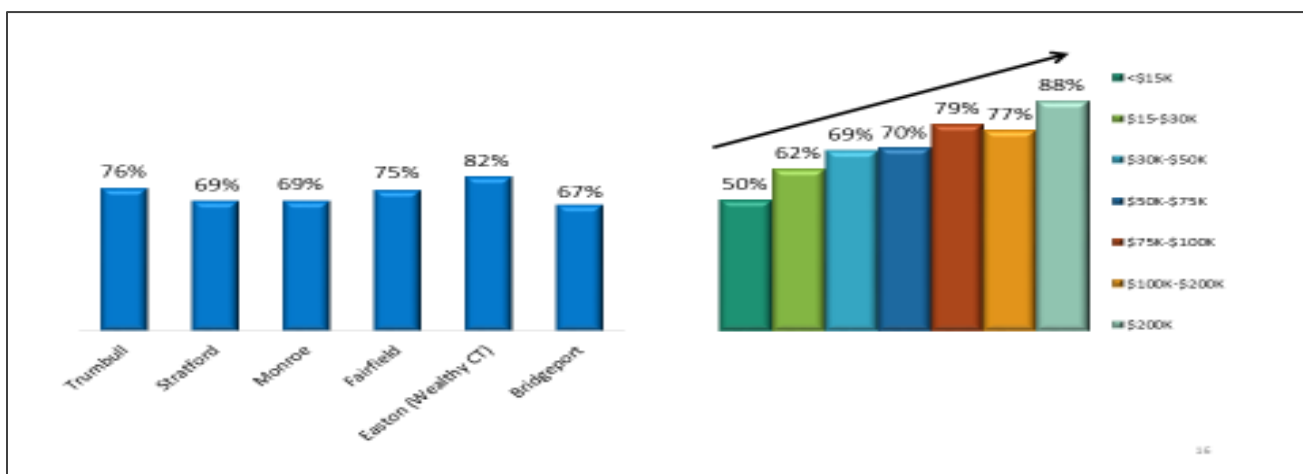
Source: 2015 DataHaven Wellbeing Index

Mental Health

A person's level of happiness and anxiety are directly correlated to income and education as illustrated in Figures 13 and 14. Adults who reported feeling happy ranged from a low of 67% in Bridgeport to a high of 82% in Easton, and when looking at income, happiness rates increased with income level.

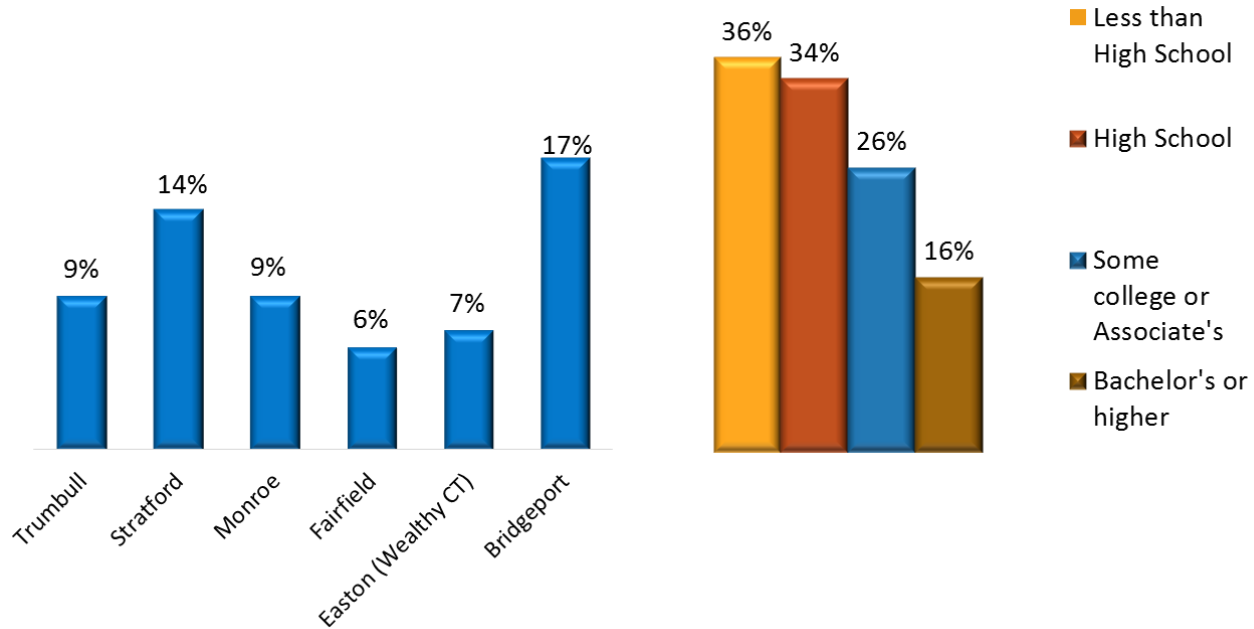
Adults who do not have a high school degree are three times more likely to feel anxious as those who have completed college or more. In addition, residents in Stratford (14%) and Bridgeport (17%) reported higher rates of anxiety as compared to their suburban counterparts (6% to 9%).

Figure 13: Respondents Who Felt Happy Yesterday (% of adults)



Source: 2015 DataHaven Wellbeing Index

Figure 14: Respondents Who Felt Anxious Yesterday (% of adults)



Source: 2015 DataHaven Wellbeing Index

E. REGIONAL FOCUS GROUPS

Focus group participants contributed to discussions and completed a short survey tool at the end of the session. On the survey, participants were asked to rate access to health care services and access to community services. Mental and behavioral health services were identified as the most challenging to access followed by access to bi-lingual providers and transportation to and from facilities for health care appointments. Participants indicated that access to open spaces and parks, grocery stores and farmers' markets, medical insurance, sport facilities and community centers, sports programs and healthy food was often available; more challenging was access to help with housing, transportation, and employment/job training. Surveys also included a self-reported ranking of the top health care issues in the community and the greatest challenges/barriers perceived to have a negative impact on the health of community residents. In both instances, access to healthcare issues had the greatest prevalence.

Focus group discussions around the positive and negative aspects of health care services in the community centered around access to care (availability of health care providers, insurance related issues, transportation challenges, prescription medication issues, dental care and vision care, wait times), coordination of care, mental and behavioral health services, and quality of care. When probing on the health and wellbeing of the community, discussions lead to access and affordability of healthy food, safety (housing, outdoor spaces, biking), and community parks and recreation options.

During the discussions, participants were asked to identify the top health concerns and issues in the community. Following is a list of the areas that were identified in the Greater Bridgeport Region:

- Coordination of care (Modes of communication within medical care facilities)
- Cost of health care (High expense of health care especially for those on state insurance)
- Dental care (Difficult to access when on state insurance; high cost for everyone)
- Healthy food (Not affordable; farmers' markets are not easy to access; high cost is a barrier)
- Housing Authority (Upkeep of facilities; safety issues in communities; communication between various agencies)
- Insurance (Those with state insurance have limited providers, long wait times, and challenges with prescription medication coverage)
- Mental health services (Stigma attached to mental health services; those on state insurance do not feel they would receive services at the clinics they use; limitations in the number of providers available)
- Quality of care (Inexperienced doctors working at local clinics; prejudice that impacts treatment for those who are not legal immigrants)
- Recreation options (The need for low or no-cost options)
- Safety (Members of public housing did not feel safe in their neighborhood; needles in their yards; shootings nearby; not all units have outside lighting)
- Seniors (Concern for senior citizens who may be taken advantage of financially, especially those who have a lack of technological knowledge)
- Transportation (Limitations with public transportation)

The detailed health concerns and issues outlined by the focus group participants also confirmed that the priority areas from 2013: Cardiac and Diabetes, Healthy Lifestyles, Mental Health and Substance Abuse and Access to Care, were still consistent with current findings.

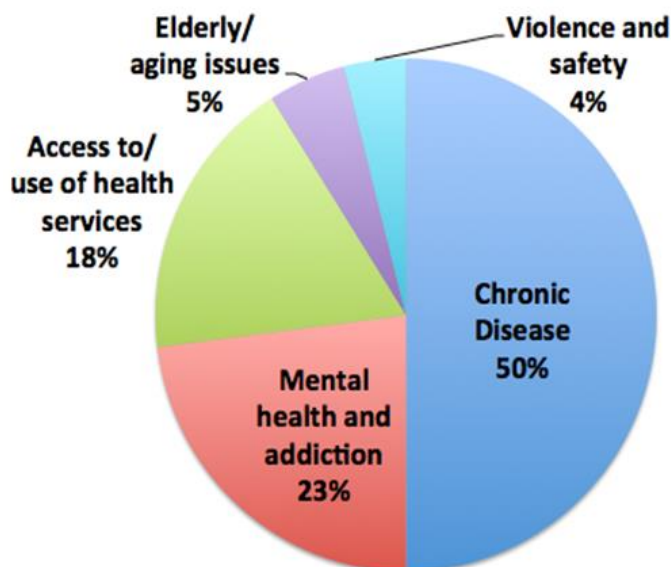
F. KEY INFORMANT SURVEYS

Efforts related to the CHNA were initiated in 2015 with a combination of primary data components including the online key informant survey administered and analyzed by a student practicum team at Yale School of Public Health with assistance from Mark Abraham, Executive Director of DataHaven. The online survey was administered to community leaders and service providers in the Greater Bridgeport area using Qualtrics, an online survey tool. Members of PCAG identified 181 key informants between the two groups and received 64 responses in total. The Health and Human Services group included hospital administrators, state and local health departments, physicians, nurses, social service agency leaders and providers, community planning organizations, family centers and youth services, elderly services, supportive housing providers, primary care centers and recreation facilities. The Government and Community Leaders group included state and local elected officials, police and fire departments, library directors, clergy, other government agency heads, school principals, after school program providers, arts organizations, journalists, community advocacy organizations, neighborhood association leaders, chambers of commerce, and community service organizations. Surveys were designed to better understand the health needs of the Greater Bridgeport region and included questions on community health initiatives, health related problems, barriers to good health, health services, and current outlooks.

From the key informant online surveys, it was found that more respondents knew about the 2013 Community Health Needs Assessment than the Community Health Improvement Plan, and more than half of the respondents believed the CHNA and CHIP led to greater collaboration in their community.

Recurring themes in responses identified the top five health issues respondents believe are present in the community as: chronic disease; mental health and addiction; access to and use of health services; aging issues; violence and safety (Figure 15). The top health issues identified by the key informants align with the health priorities confirmed in 2013 (Cardiac and Diabetes, Healthy Lifestyles, Mental Health and Substance Abuse and Access to Care).

Figure 15: Key Informant Survey Top Five Health Issues





Nearly all respondents believed that access to medical insurance was the most important barrier that should be addressed. Over half of all respondents thought that access to quality care had improved over the past three years. Some of the reasons attributed to this improvement were greater collaboration among organizations, expansion of the Affordable Care Act to increase number of insured individuals, and expansion of health care services and clinic hours. However, respondents felt there could be more emphasis on improving infrastructure and addressing homelessness.

Key informants identified leadership activities that are working well in the community as well as emerging issues. This included obesity, teenage pregnancy, mental health service access, lack of funding, violence and cyber bullying, and insufficient funding to improve built environment. Final recommendations to address health concerns included:

- Improve accessibility of transportation
- Increase number of bilingual health providers
- Increase the number of after school programs and education classes
- Engage political leaders to improve collaboration

V. COMMUNITY ENGAGEMENT

In May 2016, an overview of the CHNA process and specific findings were disseminated at two community forums. On May 6, 2016, 36 PCAG members and additional community stakeholders representing 19 organizations attended a community health improvement planning session. On Monday, May 16, 2016, 65 community members attended a community forum with representation from 32 unique organizations and groups. At both sessions the groups received an overview of the community health needs assessment including a review of the purpose and scope, the 2013 progress to date, the 2016 primary and secondary data findings, and the 2016 focus area goals and strategies within each of the four priority areas. Participants were given an opportunity to confirm 2016 priorities, draft implementation strategies, and identify additional partners. Attendees were also given the opportunity to break out into smaller groups (by town or city) to discuss additional health issues that were identified as unique to the individual towns within the Greater Bridgeport region.

The 2016 Fairfield County Community Index, prepared by DataHaven, serves as the CHNA document for Bridgeport Hospital and St. Vincent's Medical Center along with the City of Bridgeport Health & Human Service Administration, Fairfield Health Department, Monroe Health Department, Stratford Health Department, Trumbull Health Department, and other members of PCAG. The Index will be made widely available through individual members' websites.

VI. PRIORITIZATION OF HEALTH ISSUES

A. 2013 COMMUNITY HEALTH IMPROVEMENT PLAN PROGRESS-TO-DATE

In 2013, over 100 individuals from PCAG and their community partners (including Bridgeport Hospital, St. Vincent's Medical Center, local health departments, community agencies, faith-based organizations, community health centers, universities, town and city agencies and residents) completed a CHNA and prioritization process to identify priority health issues.

From this work, four areas of focus were selected including: Cardiovascular Disease and Diabetes, Obesity (Healthy Lifestyles), Mental Health and Substance Abuse and Access to Care. Since that time, progress has been made in the greater Bridgeport region including:

- Cardiac and Diabetes
 - Developed a Cardiac and Diabetes Provider Directory
 - Conducted almost 800 Know Your Numbers screening at community sites over three years
 - Worked with community feeding programs to encourage healthier food choices in food pantries and soup kitchens
- Obesity (Healthy Lifestyles)
 - Launched Get Healthy CT website; a clearinghouse of information around healthy eating and physical activity with monthly health features
 - Includes local resource directories, monthly health feature, workplace wellness ideas, and daycare center best practices
 - Provided healthy lifestyles education at community events
- Mental Health and Substance Abuse
 - Established a high ED Utilizer Mental Health Patient Community Care Team and is fully operational
 - Supported several public awareness campaigns to de-stigmatize issues around mental health and provide training to providers and support to patients and their families
- Access to Care
 - Increased number of primary care and specialty clinic visits while reducing wait times for appointments
 - Developed and implemented (at clinics and EDs) a brochure on the need for a Primary Care Medical Home
 - Advocated for the use of Community Health Workers
 - Participated in Statewide Asthma Reduction Initiative

B. 2016 PRIORITIZATION OF HEALTH ISSUES

In March 2016, PCAG members and their community partners (including those with public health departments and / or knowledge, information, or expertise relevant to the health needs of the community or medically underserved, low-income, and minority populations) reviewed the primary and secondary CHNA data and determined, by group consensus, that the 2013 priorities would be maintained moving forward for the 2016 CHNA (Figure 16). PCAG, health departments, and hospitals confirmed that there was a need to continue working in the 2013 focus areas as these were still the top health priority areas. All primary and secondary data that was collected, analyzed and reviewed supported the continuation of the 2013 priority areas.

Figure 16: Primary Care Action Group Priority Health Areas

